Bio-Crime: The Criminalization of HIV in Canada

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Abstract

HIV criminalization refers to the criminal prosecution of persons with HIV in instances of transmission and non-disclosure. Over the past two decades, HIV criminalization has emerged as a global phenomenon. Canada has the dubious honour of being a leader in this regard, having one of the highest levels of criminal prosecution for HIV-related offenses in the world. One reason is that jurisprudence in Canada developed to include actual transmission of HIV and the risk of transmission of HIV. The Supreme Court of Canada has affirmed the constitutional validity of this use of the criminal law in situations of HIV non-disclosure based on the legal principle of "fraud capable of vitiating consent to sexual relations." The paper looks at the historical development of this principle in Canadian jurisprudence and how it has come to be applied to cases of HIV non-disclosure. It also considers how epidemiological knowledge has been incorporated into this legal reasoning. The paper considers criticism of HIV criminalization from the perspectives of public health and human rights. Taking these criticisms into account, the paper concludes with two policy options for HIV criminalization in Canada.

Introduction: HIV Criminalization in Canada

HIV criminalization is a term that describes the criminal prosecution of persons with HIV in instances of transmission and non-disclosure. In the past two decades, HIV criminalization has emerged as a global phenomenon. Many countries have introduced HIV-specific criminal statutes, and many others have begun to apply pre-existing criminal laws to situations of HIV transmission and non-disclosure (United Nations, Global Commission 2012). For example, in Arkansas, HIV non-disclosure is criminalized in the circumstance of any "intrusion, however slight, of [...] any object into a genital or anal opening of another person's body" (A.C.A. § 5-14-123 2015). Currently, in the United States, 24 states have laws that explicitly target the non-disclosure of HIV status; in the rest, non-disclosure has been prosecuted under general criminal laws (Burris et al. 2007).

In Canada, there are no substantive laws relating to HIV, but transmission and non-disclosure have been prosecuted under existing charges of common nuisance, sexual assault, aggravated assault, aggravated sexual assault, administering a noxious substance, attempted murder and murder.

In addition to being a new area of law, HIV criminalisation is also an expanding area of law. Canada has the dubious honour of being a leader in this regard having one of the highest levels of criminal prosecution for HIV related offenses in the world, and the rate of prosecution has consistently increased every year since the early 1990s (Grant 2011). A reason for this is that the jurisprudence in Canada has developed to include actual transmission of HIV and the risk of transmission of HIV. This means that people can be convicted of criminal offences where no actual HIV transmission has taken place. For instance, Canada is the only country with a murder conviction for failing to disclose HIV status (R v Aziga 2011). The Aziga case illustrates both the criminalisation of actual transmission AND the risk of transmission, as Aziga was convicted for aggravated sexual assault where there was only a risk of transmission (4 victims) and where he infected others (5 victims). This case shows how Canadian jurisprudence puts actual transmission and the risk of transmission on the same level. Such a broad approach to criminalisation is responsible for growing rates of charge and conviction, and countless criminal investigations (Mykhalovskiy and Betteridge 2012). It has also resulted in relatively well developed jurisprudence on the criminalisation of HIV. In a series of decisions, the Supreme Court of Canada (SCC) has affirmed the constitutional validity of the use of the criminal law in situations of HIV non-disclosure, and elaborated the conduct, circumstances, and intention needed for conviction of a criminal offense. The legal principle on which it is based is known as 'fraud capable of vitiating consent to sexual relations.' There are three phases to the history of the development of this principle. To understand how it has come to apply to HIV non-disclosure it is necessary to understand this history.

"Fraud Capable of Vitiating Consent to Sexual Relations"

The first phase of jurisprudence on fraud in the context of sexual relations begins in the 19th Century and reflects a view that failure to disclose a serious sexually transmitted disease could constitute fraud vitiating a partner's consent to sexual relations. In R v Flattery in 1877, a conviction of rape was upheld for a man operating a booth at a fair who had sex with a woman under the pretext of a medical procedure. The court held that the victim had consented to medical contact, not the sexual act. Thus, her consent was vitiated by his fraud. In other cases, courts accepted the idea that concealment of venereal disease amounted to fraud vitiating consent. In R v Sinclair in 1867, the Court found fraud vitiating consent for non-disclosure of gonorrhoea on the basis that the complainant "would not have consented if she had known" and that "her consent is vitiated by the deceit practised upon her" (p. 29; see also R v Bennett 1866; R v Dee 1884). These early cases reflect an open-ended approach to the definition of consent and when it might be vitiated by fraud in the context of sexual relations. Rather than precisely define the term, the courts took up the question on a case-by-case basis and centred "the right of the woman involved to choose whether to have intercourse or not" (Mabior 2012, para. 31).

This precedent began to change as courts began to incorporate Victorian notions of sexual morality into the determination of fraud in the context of sexual relations (Mabior 2012). The case that began the change was Hegarty v Shine (1878). The facts of the case are that Mr. Shine had sexual relations with a domestic servant. She sued him after she became pregnant and both her and the child were infected with syphilis. The court dismissed the case against Mr. Shine on the basis of ex turpi causa non oritur action (from a dishonourable cause an action does not arise). The invocation of this legal principle meant that the court believed the plaintiff was the victim of her own immoral act, which it would not condone by bringing a judgment against the defendant: "In the case before us the plaintiff actively consented to the very thing, that is to say, sexual intercourse, with full knowledge and experience of the nature of the act" (130). In this sense, the court considered the status of the complainant's sexual morality in determining fraud. In line with Victorian thinking at the time, STI transmission was understood to be a consequence of sexual immorality. At issue for the court, therefore, was who was morally responsible for the syphilis infections, not whether the complainant's consent was vitiated by Mr. Shine's non-disclosure of his infected status.

The case that finally reversed R v Flattery is The Queen v Clarence (1888), which was influenced by the reasoning in Hegarty v Shine. The facts in this case are that a husband did not disclose to his wife that he had gonorrhoea and he infected her. He was charged with assault and unlawful inflic-

tion of bodily harm and found not guilty. The opinion in Clarence was that the victim could not claim that her consent was fraudulently obtained because she consented to a sexual act she was responsible whatever the consequences. The court held that fraud in the context of sexual relations had been interpreted too broadly in the past, and limited it to situations where the complainant was deceived as to the sexual nature of the act or the identity of the sexual partner. The subsequent "Clarence test" created a precedent that fraud could not vitiate consent to sexual contact unless the fraud was active and pertained to the sexual nature of the act or to the identity of the partner (Mabior 2012, para. 33).

Legislation passed by Parliament after Clarence reflected this narrower view. The first Canadian Criminal Code defined fraud for purposes of rape and indecent assault as "false and fraudulent representations," as opposed to simple concealment or omission, and the subject of the fraud was explicitly limited to "the nature and quality of the act" (ss. 259(b) and 266). Therefore, if an individual consented to a sexual act with a given person, no matter what the deceit involved, that person could not be convicted for the act. Needless to say, there are few if any convictions for fraud in the context of sexual relations because of the practical implications of the Clarence test. Fraud could not vitiate consent in all but rare cases because cases where an individual consents to sex but does not think it is sex or thinks it is sex with a different person are rare (Mabior 2012; see also R v Harms 1943; Bolduc v The Queen 1967).

Recently, however, Canadian law has entered a "post-Clarence era" (Mabior 2012, para. 43). As part of the implementation of the Charter of Rights of Freedoms in 1982, Parliament undertook a reform of the law on sexual offences that aimed at eliminating sexual discrimination and protecting the Charter right to security of the person. In 1983, it amended the definition of fraud in the context of sexual offenses in the Criminal Code by dropping the qualifying phrase "false and fraudulent representations" and stating simply "fraud [as to the] nature and quality of the act" (s. 265(3) (c)). The courts interpreted this change as reflecting Parliament's intent that fraud should be interpreted more broadly than it had been during the Clarence era and began to be guided by Charter values, which require "full recognition of the right to consent or to withhold consent to sexual relations" and imply "an understanding of sexual assault based on the preservation of the right to refuse sexual intercourse" (Mabior 2012, paras 43 and 45).

HIV Enters the Criminal Law

It is the more open ended approach to the interpretation of 'fraud' in the context of sexual relations that has lead to it being applied to cases of HIV non-disclosure. The SCC offered the first framework for adjudicating HIV non-disclosure cases in 1998 in R v Cuerrier, which advanced the idea that "failure to

disclose that one has HIV may constitute fraud vitiating consent to sexual relations" (Cuerrier 1998, para 373). The idea is that the non-disclosure of one's HIV status is a fraud that renders the consent of a sexual partner void under the circumstance that it exposes them to a "significant risk of serious bodily harm" (Cuerrier 1998, para 373). "Serious bodily harm" in this context being the transmission of HIV by the non-disclosing partner. However, the SCC did not define what exactly constituted a "significant risk" of transmission. Some judges placed a great deal of weight on whether the sex involved a condom (e.g. R v Agnatuk-Mercier 2001; R v Edwards 2001; R v Smith 2007). Others found culpability even when a condom was used (e.g.: R v JT 2008). The result was differing interpretations of significant risk of transmission by police, prosecutors, and lower courts, and a lack of clarity as to when individuals living with HIV have a duty to disclose their HIV status to sexual partners (Mykhalovskiy 2011). Thus, the Cuerrier decision was criticised for a lack of clarity that contributed to high levels of prosecution (78% of cases prosecuted for HIV non-disclosure result in conviction) (Mykhalovskiy and Betteridge 2012).

In the wake of *Cuerrier*, courts were urged to more precisely define "significant risk" so as to clarify who would be affected by the duty to disclose (Grant and Betteridge 2011; Mykhalovskiy 2011). The SCC responded to these calls in two decisions in 2012 in *R v Mabior* and *R v DC*. These cases provided the SCC with an opportunity to revisit the approach in *Cuerrier* in light of new epidemiological information and scientific advancements in the treatment of HIV that reduce the risk of transmission. While the SCC's reasoning in these two cases remained consistent with *Cuerrier*, it elaborated the threshold of "significant risk of serious bodily harm" to mean "a realistic possibility" of transmission of HIV (*Mabior* 2012, para 5). Thus, the duty to disclose is not absolute, but applies in contexts where non-disclosure of HIV would put a sexual partner at a *realistic* risk of HIV transmission.

Epidemiological Knowledge Enters the Criminal Law

The determination of the threshold of a realistic possibility of HIV transmission necessitated the uptake of health information by the Court. Indeed, several interveners argued that an individual's HIV viral load should be taken into account in determining a realistic risk of transmission because evidence suggests that antiretroviral therapy reduces the risk of HIV transmission greatly (*Mabior* 2012). To this end, the SCC relied on an epidemiological report prepared by an expert physician, Dr. Smith. The report noted that sexual transmission of HIV has been widely studied and male to female transmission rates are well documented (*Mabior* 2012, para. 4). Smith's report also stated that the baseline risk of HIV transmission per act of vaginal intercourse with an infected male partner (i.e. the risk of trans-

mission based on the male having a normal unreduced viral load and ejaculating without a condom) ranges from 1 in 2000 to 1 in 384. Dr. Smith also suggested that condom use lowered this risk by 80% and having a low or undetectable viral load lowered it by at least 89% (*Mabior* 2012, para. 4). Referring to this epidemiological information, the SCC determined that without both condom use and a low viral load there is a legal duty to disclose one's HIV status to sexual partners. Mabior established that condom use and a low viral load together reduce the risk of transmission of HIV from "realistic" to "merely speculative" (Mabior 2012, para. 101). There is no duty to disclose one's status if both these conditions are met. In this way, the SCC integrated epidemiological knowledge into the legal framework established in *Cuerrier*.

It may seem as if Mabior was in part a return to the pre-Clarence era in Canadian law on fraud in the context of sexual relations. However, there are important differences from the 19th Century approach. The legal reasoning in the early cases was not based on the individual right to refuse consent to sexual relations. The original jurisprudence reflected a focus on the protection of womanly virtue and the assumption that complainants in a scenario where fraud could vitiate consent to sex would always be women. In contrast, the contemporary legal reasoning centres the complainant's right to refuse sexual contact based on the idea that each sexual partner is an autonomous individual. At the same time, instead of Victorian morality, the courts have had to draw on epidemiological information to define a realistic risk of HIV transmission. Taken together, these two differences represent an important shift in legal reasoning away from the question of sexual morality and toward the question of whether an individual's right to refuse sexual relations was vitiated by a partner's deceit. In making this determination, the association between transmission of sexually transmitted diseases and sexual immorality seem to have been replaced by a focus on the biological status of the individual body.

HIV Criminalization and Public Health

The *Mabior* decision triggered significant debate, much of which is echoed in discussions in the US and elsewhere on the criminalisation of HIV. Defenders of the criminalisation consistently invoke arguments justifying the use of the criminal law to address social problems more generally: incapacitation, rehabilitation, retribution, and deterrence (Heneke 2009; Hermann 1990; Kaplan 2012). As Lazzarini et al. (2002) summarises, proponents of HIV criminalisation argue for the use of the criminal law based on the assumption that the threat of punishment deters unsafe behaviour; that it might help convince people with HIV that unsafe behaviour is wrong; that it would support a general social norm against unsafe behaviour; and that it would incapacitate those who have a propensity toward certain unsafe behaviours through imprisonment (239).

In essence, pro-criminalisation arguments made in the context of HIV/AIDs maintain that using the criminal law against non-disclosure is important for protecting potential sexual partners of HIV-positive individuals and for stigmatising the act of HIV non-disclosure in general (Galletly and Pinkerton 2004; Strader 1994; Wolf and Vezina 2004).

The arguments against HIV criminalisation came from public health experts as well as HIV/AIDs activists, among whom there seems to be a rejection of the SCC's affirmation of any duty to disclose at all (Burris and Cameron 2008; Eba 2008; Grace and McCaskell 2013; Jürgens et al. 2009; Klemm 2010). While many had argued that scientific knowledge should be incorporated into legal responses to HIV, the knowledge they were referring to was the advancements in treatment and evidence-based public health. From this perspective, the *Mabior* ruling was interpreted as an extension of criminalisation because it required having a low viral load in addition to condom use, rather than simply the latter. Critics have pointed out that not all individuals with HIV are able to access the treatment needed to achieve a low viral load. Variance in access to antiretroviral therapy means that some segments of HIV infected population will be forced to disclose while more privileged individuals can avoid criminal liability altogether. Activists also point out that even the decision to use a condom is not simple and not always mutual. Some people will not be able to insist on condom use for complex reasons, including power differentials (Canadian HIV/AIDS Legal Network 2012).

In general, public health approaches reject criminalisation of HIV as a way of stopping the transmission of HIV. They argue that criminal punishment will not deter or incapacitate the transmission of HIV because of the criminal law focus on individual responsibility and moral blameworthiness, which fails to account for the structural factors that drive the HIV/AIDs epidemic (Grace 2012; Mykhalovskiy 2011). For instance, public health research shows that there is an increased risk of transmission of HIV during the first eight weeks following infection. This suggests that most transmissions of HIV occur because individuals do not know their status, not because they are hiding their status. Thus, public health advocates emphasise that an individual is more likely to get tested if they do not fear stigmatisation, as well as the need for "voluntariness, confidentiality, and education" to encourage early testing (Klemm 2010, 505). From this perspective, if the criminalisation of HIV contributes to stigmatisation if HIV it will discourage people from getting tested voluntarily (Brook 2012; Cornett 2011; Timmermans and Gabe 2003). The possibility of criminal liability could function as "a perverse incentive not to find out one's disease status" (Fan 2012, 572).

Criminalisation also complicates the role of health officials, who aim to establish a relationship of trust with patients in

order to foster compliance with medical treatment. In the health domain, it is recognised that an effective therapeutic relationship depends on honest and open communication between doctor and patient. This is why physician-patient privilege is sacred (however not absolute). As a result of criminalisation, however, things said during some health counselling sessions could potentially become evidence in a criminal trial to establish that an accused was aware they had HIV and were informed of their duty to disclose to sexual partners.

Finally, criminalisation could be argued to harm public health in yet another broader way. It conflicts with public health goals because of the nature of incarceration, which epidemiological studies have shown leads to increased rates of transmission of HIV in prisons, which in turn impacts the spread of HIV in the wider society (Elliott 2002). Thus, increasing incarcerated populations, regardless of the offense can have a negative public health impact.

HIV Criminalization and Human Rights

In addition, there are also criticisms of the criminalisation of HIV that come from a human rights perspective. Arguments based on this approach note the need to protect the human rights of those with HIV in the course of public health responses. Thus, they focus on obligations created by international laws and treatises, such as the Universal Declaration of Human Rights, including the right to equality before the law; the right not to be coerced into disclosure; the right to liberty, dignity, and freedom from cruel, inhumane, and degrading treatment; the right to information and education; the right to health; and the right to participate in public life and decisionmaking (Kelly 2012). From this perspective, the criminalisation of HIV is unacceptable because it violates the right to privacy and security of the person, for example by criminalising biological status and stigmatising individuals living with HIV using medical categories of risk (Langley and Nardi 2010). No response to the HIV epidemic will be seen as effective from this perspective if it involves law and policies that violate the human rights of people living with HIV (Kelly 2012). Thus, human rights discourses emphasise that voluntary compliance and increased access to treatment are the most effective mechanisms for controlling the spread of HIV, and argue that legal measures should only be directed at fostering compliance, not punishing non-compliance.

Policy Options for Canada

Given the fact that individuals are charged and convicted for HIV non-disclosure more often in Canada than in other jurisdictions, and the public health and human rights concerns this raises, it is worth considering policy options that could address some of the issues. This section considers two such policy options. The guiding principles behind them both are the use of evidence-based approaches, and ensuring that any application of the criminal law achieves justice and supports public health. To address the high rate of charge and conviction for HIV non-disclosure, one option is to narrow the set of available criminal charges for HIV non-disclosure. While HIV was once a death sentence, there is consensus in the medical community that it is now a serious chronic health condition that is manageable for the majority of those who receive treatment (UNAIDS 2013). Thus, a preferable legal approach may be to consider HIV as one of a set of serious sexually transmitted diseases that require lifelong treatment (herpes, hepatitis, antibiotic-resistant gonorrhoea), rather than a case on its own. From this perspective, it would arguably be inappropriate to criminally prosecute HIV non-disclosure using charges of attempted murder, aggravated assault or aggravated sexual assault. Using this framework, courts in Canada would also have to justify how, if at all, the law on fraud vitiating consent applies to cases of non-disclosure of serious sexually transmitted diseases besides HIV.

Another option is to once again reassess the meaning of "significant risk" in light of the most recent epidemiological information. It makes sense that the best available scientific evidence should perpetually inform legal determinations of the significant risk of HIV transmission. While the SCC did consider such evidence in Mabior, it is arguable that the bar was set too high by requiring both a low viral load and condom use. A court in Switzerland acquitted a person living with HIV of charges of "attempted spread of disease" and "attempted serious bodily harm" because he was on "proper antiretroviral treatment, had undetected [viral load]" and could not transmit HIV (S v S and R 2009). A low viral load was also recently declared by UNAIDS (Joint United Nations Program on HIV/ AIDS) as just as effective as condom use in reducing the likelihood of transmission of HIV, and it recommended that based on the independent effectiveness of both methods in reducing HIV transmission condom use and low viral load be recognized separately as sufficient to exclude criminal liability (2013).

Keeping in mind the human rights criticisms above, recognising condom use and low viral load as separate defences could also be justified on moral grounds because marginalised populations are more likely to be affected by the duty to disclose. In 2011, only 54% of people eligible for antiretroviral therapy in low-and middle-income countries were receiving it, and it is estimated that a third of those living with HIV in Canada are not receiving treatment (UNAIDS 2013). This group includes the most marginalised members of the HIV positive population, including sex workers, the poor, those with addictions, and Aboriginal people and Black Canadians, as each of these groups face disproportionately higher rates of HIV infection and relatively less access to treatment (Grace 2012: 162; MacKinnon

and Crompton 2012, 416). Consistent condom use is one of the few methods of HIV prevention that is affordable and accessible to individuals who are not on treatment and/or who do not have a low viral load. Recognising condom use as a separate defence would enable these individuals to protect themselves against prosecutions for non-disclosure of HIV in the context of sexual relations. Thus, if the courts in Canada were to accept such reasoning it would make the criminalisation of HIV more consistent with international human rights imperatives.

Conclusion

To be on the receiving end of an HIV diagnosis in Canada today is to be confronted with a requirement of perpetual assessment of one's viral status in ways that affect one's legal liabilities. This implicates not only diagnosed individuals with access to treatment in an ethic of continual disclosure, but also those that are not in treatment in a condition of perpetual surveillance. It also implicates a vast, socio-technical network of health professionals and government officials that create new legal risks for persons living with HIV. The criminalisation of HIV is an important area of law because of its relation to emerging forms of what has been called "biosociality" (Rabinow 1996) or "biological citizenship" (Petryna 2002; Rose and Novas 2005). These terms try to capture the overlap between medical knowledge and legal meaning, and between individual biological status and criminal liability.

The Mabior principle sets a standard for criminal liability that is connected to the body's biological status, which considered in conjunction with public health and human rights perspectives, divides the population of those living with HIV/ AIDs by degrees of criminally liability. This is because criminal liability is in part determined by biological risk factors such as having a low viral load. This arguably creates a stigmatized viral underclass in that those most affected by criminalisation will be the most marginalised segments of the HIV positive population (Burris and Cameron 2008). Given the legal framework that has developed in the area of HIV criminalisation in Canada, however, policy options that could address some of the public health and human rights criticisms include narrowing the set of available criminal charges for HIV non-disclosure by considering HIV as one of a set serious STIs and reassessing the meaning of "significant risk" in order to recognise condom use and low viral load as separate legal defences.

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